Co-Occurring Academy: Action Plan for Alabama

PRIORITY 1: ***Establish the formal organizational infrastructure needed to transform separate mental illness and substance abuse systems of care into an integrated service delivery system for individuals with co-occurring disorders.***						
Strategy(-ies)	**Action(s)**	**Manager[1]**	**Implementer[2]**	**Expected Outcomes**	**Benchmarks**	**Completion Date (Estimated)**
1.1 Articulate the adoption, establishment, and implementation of the Comprehensive Integrated System of Care (CCISC) as the system change model to be used by the state of Alabama.	**1.1.1** A state charter document is developed that encompasses the eight principles of the CCISC and reflects the consensus and endorsement of the DMH planning bodies that was provided in 2002 and 2004.	Sarah Harkless	Sarah Harkless	A charter document exists.	1. Proposed charter presented to CODC at June 2004 Meeting. 2. CODC meeting minutes reflect progress in charter development.	July 31, 2004
	1.1.2 Governor Riley and DMH Commissioner Sawyer formally endorse and sign the consensus document.	Sarah Harkless	Kent Hunt/Kim Ingram	A signed charter exists.	1. DMH Commissioner receives charter by 08/01/04. 2. Governor receives charter by 09/01/04. 3. CODC meeting minutes reflect progress towards endorsement.	September 30, 2004
	1.1.3 Governor Riley and DMH Commissioner Sawyer convene a meeting of the executive and clinical directors of all DMH funded substance abuse and mental illness programs, at which: a. The charter document is disseminated; b. Expectations of programs funded by DMH relative to this document are clearly communicated; and c. Dr. Ken Minkoff provides overviews of the CCISC and the integrated systems planning process.	Sarah Harkless/Molly Brooms	Governor, Commissioner, Kim Ingram, Kent Hunt, CODC, Dr. Minkoff	1. Leadership of provider organizations understand DMH's commitment to improve care for individual s with co-occurring disorders. 2. Leadership of provider organizations understand DMH's expectations of their agencies.	1. Resources identified to support meeting by 07/31/04. 2. Dr. Minkoff contacted by 7/31/04 for meeting date availability. 3. Commissioner and Governor agree to meeting date by 8/30/04. 4. Executive directors contacted by 09/30/04	November 30, 2004

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	1.1.4 Incorporate the charter into provider contracts.	Kim Ingram/Kent Hunt	Kim Ingram/Kent Hunt	Provider contracts reflect charter language.	1. Charter language condensed for inclusion inn contract by 08/31/04. 2. Modification submitted to contract division by 9/30/04.	December 31, 2004
1.2 Establish the leadership structures necessary to support systemic change.	**1.2.1** Clearly defined roles of existing DMH personnel relative to the change process are delineated, and formalized in writing.	Sarah Harkless	Sarah Harkless/Molly Broom (Until co-occurring director is hired)	Document exists that defines role of DMH personnel participating in the systems change process.	1. Role definitions developed by 8/30/04. 2. CODC reviews roles by 9/30/04. 3. CODC recommendations submitted to appropriate committees for review and approval by 10/31/04.	November 30, 2004
	1.2.2 Clearly defined policies for the CODC are established and formalized in writing.	Molly Broom	Sarah Harkless/Molly Broom (Until co-occurring director is hired)	A document exists that defines the role and responsibilities of the CODC.	1. Role and responsibilities defined by 8/30/04. 2. CODC reviews recommendations by 9/30/04. 3. CODC recommendations submitted to appropriate committees for review and approval by 10/31/04.	November 30, 2004

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Strategy(-ies)	Action(s)	Manager[1]	Implementer[2]	Expected Outcomes	Benchmarks	Completion Date (Estimated)
	1.2.3 A team of "change agents" is hired by DMH to support implementation of the CCISC: d. The Co-occurring Disorders Program Director e. Substance Abuse Treatment and Prevention Specialist f. Mental Illness Treatment Specialist g. Outreach Specialist h. Data Manager i. Administrative Assistant j. A Psychiatric Consultant k. An Addictionologist Consultant	Kim Ingram/Kent Hunt	Sarah Harkless, Molly Broom, CODC, DMH Personnel Office	Adequate staff will be secured to fully implement the CCISC.	1. Funding secured. 2. Commissioner approval obtained 3. Job Descriptions developed 4. Training and orientation plans developed. 5. Positions Announced. 6. Interviews held 7. Individuals hired	All positions filled by April 30, 2005.
	1.2.4 Orientation and training for the state team is provided.	Sarah Harkless/Molly Brooms	DMH SAS, MI, and Staff Development Divisions, Dr. Minkoff	Employees will report and demonstrate an understanding of their job responsibilities.	1. Training and orientation schedules developed. 2. Training administered.	May 30, 2005
1.3 Effectively keep stakeholders informed of implementation of the CCISC, subsequent progress, and other issues relative to co-occurring disorders.	**1.3.1** A social marketing plan is developed and implemented.	COD Program Director	COD Program Staff, CODC	The general public, collaborating agencies, legislators, consumers, families and others will have improved access to information about co-occurring disorders, and the treatment services available.	1. Resources gathered to assist in plan development. 2. Marketing plan developed. 3. Stakeholder mailing list developed. 4. Plan recommendations submitted to appropriate committees for review and approval.	June 30, 2005

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	1.3.2 A DMH co-occurring disorders web site is established.	COD Program Director	COD Program Staff, Data Management Staff, CODC	Improved access to local, state, and national information about co-occurring disorders.	1. Funding resources identified to develop Web site. 2. Application requirements identified. 3. Site design approved, as appropriate	Web site operational by 10/01/05.
1.4 Empower community providers to become active participants in the change process.	**1.4.1** Meetings are conducted in each of Alabama's twenty-two Mental Health Authority Regions to orient and inform providers of the CCISC and DMH's expectations relative to serving individuals with co-occurring disorders.	COD Program Director	COD Program Staff	Providers will have an understanding of what is required of them, as well as, resources available to assist them, relative to the provision of COD services.	1. Meeting agendas developed. 2. Site visits scheduled, and staff members assigned to sites.	All site visits completed by 12/31/04.
	1.4.2 Utilize the COMPASS™ to establish baseline fidelity scores for each provider organization to support evaluation of the effectiveness of infrastructure enhancements.	COD Program Director	COD program Staff, SA and MI Division Staff, Dr. Minkoff	Baseline fidelity scores will exist for each provider agency.	1. Licensure for COMPASS™ obtained. 2. Process for implementation developed.	Baselines established by 01/01/05.
	1.4.3 Convene co-occurring academies in each of the twenty-two Mental Health Authority Regions to identify regional needs, resources, barriers, opportunities for collaboration, provider roles in the regional co-occurring disorders service system, and to develop a regional strategic plan based upon the principles of CCISC.	COD Program Director	COD program staff, Co-occurring Academy Facilitator, Dr. Minkoff	A strategic plan will exist for each Mental Health Authority region in Alabama.	1. Academy process and schedule developed. 2. Academy process implemented. 3. Regional change agents identified. 4. Regional reporting process is established. 5. Regional needs identified.	March 31, 2005

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	1.4.4 Technical assistance and training is provided on a regional and provider level to support local implementation and infrastructure development efforts.	COD Program Director	COD program staff, Dr. Minkoff	Providers receive support for training and other technical assistance in accordance to needs identified in the regional strategic plans.	1. Strategic plans reviewed. 2. TA plans developed for each region. 3. Resources for TA identified.	1. Each region will have received initial training by June 30, 2005. 2. Training and TA to be an ongoing process.
	1.4.5 Incentives are provided to providers based upon benchmark achievements.	COD Program Director	COD Program Staff	Providers receive funds for attainment of identified goals towards co-occurring competency.	1. Benchmarks identified. 2. Reimbursement for benchmarks established. 3. Recommendations submitted to various DMH committees for approval. 4. Approval granted. 5. Providers informed.	June 30, 2005

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1.5 Enhance consumer/client and family participation in the planning process for systemic change for individuals with co-occurring disorders.	**1.5.1** Provide ongoing monitoring of the make up of each DMH planning body to insure adequate and appropriate consumer/client and family representation.	COD Program Director	COD Outreach Worker	Consumers and family members are appropriately represented on DMH planning bodies.	1. Develop listing of all DMH planning committees, to include racial makeup, sex, and representation on the committee. 2. Develop community contacts to insure the availability of a diverse selection of individuals willing to serve on the planning bodies. 3. Develop accommodations to support consumer/ client and family representation in the planning process, as transportation assistance, alternative meeting schedules and locations.	June 30, 2005
1.6 Enhance intra-agency and interagency participation in the planning process for systemic change.	**1.6.1** Bi-monthly information sharing meetings between DMH's substance abuse and mental illness division staffs are held.	Sarah Harkless	Sarah Harkless/Molly Brooms	Opportunities for intra-agency shared training, funding solicitations, and other resource development activities are identified and implemented.	1. Agendas established 2. Meeting dates established. 3. MI and SA staff identified and notified of meeting dates.	September 30, 2004

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	1.6.2 MOU's are developed between DMH and a wide range of state-level organizations to support provider efforts to establish comprehensive services on a local level.	Molly Brooms	Molly Brooms/, Sarah Harkless CODC	DMH will establish eight MOU's to support local provider efforts.	1. Provider needs surveyed. 2. Meeting scheduled with state agency heads to discuss collaboration. 3. MOU's drafted. 4. Recommendations submitted to the various DMH committees for approval.	January 31, 2005
1.7 Ensure that individuals representing the various races, ethnic groups, and cultures of the people of Alabama are actively included and participate in the planning process for systemic change.	**1.7.1** Provide ongoing monitoring of the make up of each DMH planning body to insure adequate and appropriate representation of individuals representing various races, ethnic groups, and cultures.	COD Program Director	COD Outreach Worker	Individuals representing the various races, ethnic groups, and cultures of the people of Alabama are actively included and participate in the planning process for systemic change.	1. Develop listing of all DMH planning committees, to include racial makeup, sex, and representation on the committee. 2. Develop community contacts to insure the availability of a diverse selection of individuals willing to serve on the planning bodies. 3. Develop accommodations to support consumer/ client and family representation in the planning process, as transportation assistance, alternative meeting schedules and locations.	June 30, 2005

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1.8 Establish a process to monitor implementation of infrastructure changes to support improvements in the system's capacity to serve individuals with co-occurring disorders.	**1.8.1** A baseline CCISC implementation fidelity score is established using the COFIT™ system assessment tool.	Molly Broom	Molly Broom, Sarah Harkless, CODC, Dr. Minkoff	A baseline score will be established for the purpose of measuring the impact of system growth towards implementation of the CCISC.	1. Licensure obtained for use of COFIT™. 2. Process for implementation of COFIT™ developed. 3. COFIT™ assessment complete.	December 30, 2004
	1.8.2 Monthly implementation reports submitted to the DMH Commissioner and to Governor Riley.	Kent Hunt	Kent Hunt, Kim Ingram, CODC	DMH Commissioner and Alabama's Governor will have up-to-date information relative to the co-occurring disorders initiative.	1. Report format developed. 2. Reports assembled and submitted every three months.	Beginning December 30, 2004.

Progress to Date	**Barriers and/or Situational Changes**	**Immediate Next Steps (including potential technical assistance needs)**
1. Submission of COSIG grant application to support infrastructure development needed for implementation of CCISC. 2. COD Program Director job description developed.	1. Funding needed.	1. Hire COD Program Director 2. Co-occurring Academy facilitator needed for 22 Mental Health Authority regions. 3. Technical assistance needed Dr. Minkoff to assess plan, present the CCISC model to state executive directors, and provide training. 4. TA needed to develop Social Marketing Strategies.

[1] The Manager is the individual responsible for coordinating each action.

[2] The Implementer is the individual (or entity) responsible for carrying-out each action.

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PRIORITY 2: ***Screen all individuals who present for treatment at DMH certified facilities for the presence of co-occurring disorders.***						
Strategy(-ies)	**Action(s)**	**Manager[1]**	**Implementer[2]**	**Expected Outcomes**	**Benchmarks**	**Completion Date (Estimated)**
2.1 An appropriate screening protocol is developed.	**2.1.1** A collection of screening instruments and supporting documentation, appropriate for identifying co-occurring disorders in multi-cultural adult and adolescent populations is assembled.	COD Program Director	CODC	1. Instruments are selected that have the potential to meet the needs of DMH relative to screening for co-occurring disorders.	1. The planned use of a screening protocol will be clearly articulated through the establishment of a common set of service eligibility guidelines, relative to diagnostic criteria. 2. Criteria to guide the search will be set relative to the planned screening process. 3. Appropriate instruments, capable of assessing service eligibility as defined by CODC, will be identified. 4. Instruments will be collected and studied for appropriateness.	April 30, 2005
	2.1.2 A task group is created to review, select, and recommend a screening instrument and process for adolescent and adult mental illness and substance abuse programs.	COD Program Director	CODC, Screening/ Assessment Protocol Task Group	1. A culturally diverse task group is selected, that includes consumer and family participation.	1. Potential task group members identified and contacted. 2. Meetings held as scheduled. 3. A recommendation is made for a screening protocol.	

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	2.1.3 The task group's recommendation is submitted to community providers and collaborating agencies for review and comment.	COD Program Director	Kathy Seifried, Molly Blooms	1. Providers have the opportunity to review and comment on task group recommendations. 2. Collaborating agencies have the opportunity to review and comment on task group recommendations.	1. Task group recommendations sent to providers. 2. Feedback received from providers and collaborating agencies.	
	2.1.4 Based upon comments received, the task group either resumes the selection process or submits the recommended protocol to DMH's planning advisory committees for a recommendation to the DMH Commissioner.	COD Program Director	Screening/Assessment Protocol Task Group, CODC, Kent Hunt, Kim Ingram	1. A screening protocol is established.	1. Task group convened to consider recommendations, and address appropriately. 2. Written policies and procedures to govern the identified screening process are developed. 3. A recommendation is submitted to DMH planning and advisory committees. 4. A recommendation is submitted to the DMH Commissioner.	
	2.1.5 An implementation plan and date is established	COD Program Director, Kent Hunt, Kim Ingram	Kent Hunt, Kim Ingram, CODC		1. Implementation date identified. 2. Providers notified of the planned implementation schedule.	

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	2.1.6 A plan for training to support implementation is established.	COD Program Director	Kathy Seifried, CODC	1. All providers receive training to implement the screening process.	1. Formal training schedule developed. 2. Providers of notified of the planned training schedule. 3. Training provided.	
2.2 All DMH providers, substance abuse and mental illness, utilize the selected screening protocol.	**2.2.1** The screening protocol is integrated in DMH standards, contract management, and quality assurance policies.	Kent Hunt, Kim Ingram	Kent Hunt, Kim Ingram, COD Program Director.	1. Policies and procedures governing screening for co-occurring disorders have been codified in all relevant DMH regulations.	1. SA and MI standards reflect the screening protocol. 2. SA and MI Contract Billing Manuals reflect the screening protocol. 3. SA and MI quality assurance policies reflect the screening protocol.	June 30, 2005
	2.2.2 Provider utilization of the screening protocol is monitored through DMH's contract monitoring, certification, and quality assurance processes.	Kent Hunt, Kim Ingram	COD Program Director, MI and SA Certification and Contract Personnel	1. Providers' policies, procedures, and clinical records demonstrate utilization of the screening protocol.	1. 50% of providers surveyed between July 1 and September 30, 2005 will be in compliance with DMH regulations. 2. 100% of providers surveyed after October 1, 2005 will be in compliance with DMH regulations.	October 1, 2005

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2.3 The screening protocol is used by related organizations that serve individuals who may need co-occurring disorders treatment.	**2.3.1** Community outreach efforts promote screening for co-occurring disorders.	COD Program Director	COD Outreach Worker	1. 25% of the organizations contacted will implement a co-occurring screening protocol.	1. Records documenting outreach efforts are maintained. 2. Various community organizations and agencies indicate an interest in implementing screening. 3. Assistance is provided to agencies to remove barriers that prevent screening.	September 30, 2005
	2.3.2 Community seminars are held at relevant agencies to promote the identification of individuals who have, or are at risk of having, co-occurring disorders.	COD Program Director	COD Outreach Worker	1. 50% of the agencies indicate willingness to screen for co-occurring disorders, or a desire to learn more about the screening and treatment referral process.	1. Records documenting seminar content, attendance, and seminar evaluation are maintained. 2. Evaluations indicate that the information provided was helpful to the organization. 3. Evaluations indicate a willingness of the agencies to screen for co-occurring disorders.	

Progress to Date	**Barriers and/or Situational Changes**	**Immediate Next Steps (including potential technical assistance needs)**
	1. Multiple "priorities" of existing personnel. 2. Funding to implement needed change.	1. Hire COD Program Director 2. TA to assist in development of appropriate screening protocol.

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PRIORITY 3: ***Assess the level of severity of co-occurring disorders in the State of Alabama***						
Strategy(-ies)	**Action(s)**	**Manager[1]**	**Implementer[2]**	**Expected Outcomes**	**Benchmarks**	**Completion Date (Estimated)**
3.1 Assessment instruments are selected and an assessment process is developed.	**3.1.1** A collection of assessment instruments and supporting documentation, appropriate for use with multi-cultural adult and adolescent populations, is assembled that can identify both a. Psychiatric and substance disorders; b. Comorbid conditions; and c. Stages of motivation and change.	COD Program Director	CODC	1. Criteria to guide the instruments' search will be set relative to the planned assessment process. 2. Appropriate instruments meeting the defined criteria will be identified. 3. Instruments will be collected and screened for appropriateness.	100% Completion of all action steps.	April 30, 2005
	3.1.2 A task group is created to review, select, and recommend an assessment instrument and process for adolescent and adult mental illness and substance abuse programs.	COD Program Director	CODC, Screening/ Assessment Protocol Task Group	1. Potential task group members identified and contacted. 2. Task group selected reflects cultural diversity and includes consumer and family participation. 3. Meetings held as scheduled. 4. A recommendation is made for an assessment protocol.		
	3.1.3 The task group's recommendation is submitted to community providers and collaborating agencies for review and comment.	COD Program Director	Kathy Seifried, Molly Blooms	1. Task group recommendations sent to providers. 2. Feedback received from providers.		

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	3.1.4 Based upon comments received, the task group either resumes the selection process or submits the recommended choices to DMH's planning advisory committees for a recommendation to the DMH Commissioner.	COD Program Director	Screening/Assessment Protocol Task Group, CODC, Kent Hunt, Kim Ingram	1. A recommendation is submitted to DMH planning and advisory committees. 2. A recommendation is submitted to the DMH Commissioner.		
	3.1.5 An implementation plan and date is established.	COD Program Director	Kent Hunt, Kim Ingram	1. Implementation date is identified. 2. Providers notified of the planned implementation schedule.		
	3.1.6 A plan for training to support implementation is established.	COD Program Director	Kathy Seifried, CODC	1. Formal training schedule developed. 2. Providers notified of the planned training schedule.		
	3.1.7 The assessment protocol is integrated into DMH standards, contract management, and quality assurance policies.	Kent Hunt, Kim Ingram	Kent Hunt, Kim Ingram, COD Program Director.	1. SA and MI standards reflect the screening protocol. 2. SA and MI Contract Billing Manuals reflect the screening protocol. 3. SA and MI quality assurance policies reflect the screening protocol.		

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3.2 All DMH providers, substance abuse and mental illness, utilize the selected assessment protocol.	**3.2.1** Provider utilization of the assessment protocol is monitored through DMH's contract monitoring, certification, and quality assurance processes	Kent Hunt, Kim Ingram	COD Program Director, MI and SA Certification and Contract Personnel	Providers' policies, procedures, and clinical records will demonstrate utilization of the screening protocol.	1. 50% of providers surveyed between July 1 and September 30, 2005 will be in compliance with DMH regulations. 2. 100% of providers surveyed after October 1, 2005 will be in compliance with DMH regulations.	October 1, 2005
3.3 Determine the prevalence of co-occurring disorders in the state through a range of epidemiological measures.	**3.3.1** DMH seeks the services of an expert organization (state procurement laws must be followed) to conduct a gap analysis to: a. Assess the prevalence of co-occurring disorders in Alabama; b. Assist in appropriate allocation of scarce state resources; c. Assist in regional planning; d. Assist in establishment of appropriate care continuums throughout the state.	COD Program Director	COD Program Director, Kim Ingram, Kent Hunt, CODC	Co-occurring prevalence rates, with supporting documentation, are established for Alabama.	1. RFP Criteria developed. 2. RFP reviewed, approved, and released. 3. Proposals reviewed and contract awarded. 4. Assessment conducted. 5. Findings submitted to DMH.	January, 2006
	3.3.2 Use of gap analysis data is evident in state and regional systems planning for co-occurring disorders services.	COD Program Director	CODC, Kim Ingram, Kent Hunt	Systems changes occur based upon prevalence data.	1. DMH planning committees' minutes reflect use of data derived from study. 2. Service enhancements reflect use of data.	October, 2006

Progress to Date	**Barriers and/or Situational Changes**	**Immediate Next Steps (including potential technical assistance needs)**
	1. Lack of personnel to implement needed changes. 2. Funding to hire additional staff	1. Hire COD Director 2. Coordinate existing state training with current state plan. 3. TA needed to enhance understanding of the CCISC

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PRIORITY 4: ***Provide seamless, comprehensive, coordinated treatment for co-occurring disorders treatment in DMH certified programs.***						
Strategy(-ies)	**Action(s)**	**Manager[1]**	**Implementer[2]**	**Expected Outcomes**	**Benchmarks**	**Completion Date (Estimated)**
4.1 There is no wrong door to services for co-occurring disorders within DMH's provider system.	**4.1.1** A treatment improvement committee is established to research and develop written protocols, policies, and procedures that define welcoming, empathic, and hopeful clinical practices for all clinicians in all settings.	COD Program Director	CODC, Treatment Improvement Task Group, Dr. Minkoff	1. Dual diagnosis capability is incorporated and communicated as an expectation in DMH policies, procedures, standards, contracts, and mission statement. 2. All DMH certified provider organizations' policies and procedures reflect dual diagnosis capability.	1. Potential task group members identified and contacted. 2. Task group selected reflects cultural diversity and includes consumer and family participation. 3. Meetings held as scheduled. 4. Policy recommendations are drafted.	September 30, 2005
	4.1.2 Committee recommendations are submitted to community providers and collaborating agencies for review and comment, with modifications made relative to feedback received.	COD Program Director	Kathy Seifried, Molly Blooms		1. Task group recommendations sent to providers. 2. Feedback received from providers.	
	4.1.3 Recommendations are channeled through DMH's planning process and incorporated into standards and practice guidelines, as appropriate.	COD Program Director	Kent Hunt, Kim Ingram, CODC, Dr. Minkoff		1. Treatment improvement task group's work utilized to guide the development of standards and practice guidelines for treating individuals with co-occurring disorders. 2. DMH's planning committee minutes reflect endorsement of the no wrong door to treatment concept.	

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	4.1.4 Consumer satisfaction surveys are monitored to assess provider implementation of the no wrong door policy.	COD Program Director	Kathy Seifried, Molly Blooms, DMH Certification staff		1. Surveys reflect provider adherence to the no wrong door policy.	
4.2 A continuum of care that includes prevention and early intervention services is available to all regions.	**4.2.1** The treatment improvement task group assembles an array of information and information resources to assist in regional planning and identification of provider roles to establish a continuum of services for priority populations.	COD Program Director	CODC, Treatment Improvement Task Group	1. A written report of recommendations exists. 2. A strategic plan is developed to address service gaps. 3. All DMH planning bodies endorse strategic plan.	1. Priority populations in need of dual diagnosis enhanced programs are identified. 2. All elements of a continuum of care for this population are identified. 3. Prevention data is utilized to assist in regional service planning. 4. Service gaps indicative of need for Dual Diagnosis Enhanced Programs are identified. 5. Strategies for implementation of needed services are identified. 6. Technical assistance obtained from all available resources.	September 30, 2006
4.3 Complimentary co-occurring disorders program certification standards for DMH's substance abuse and mental illness divisions are created and implemented.	**4.3.1** Standards task group is activated to research and develop program certification standards for Dual Diagnosis Capable and Enhanced Programs according to the principles of the CCISC.	Molly Brooms	Molly Brooms, Standards task group	Standards published in Alabama Administrative Code.	1. Minutes maintained of committee meetings and actions. 2. Recommendations include standards for cultural competency.	December 31, 2005

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	4.4.2 The task group utilizes information from provider COMPASS™ assessments to assist in this process, along with standards from other states, and best practice guidelines.	Molly Brooms	Molly Brooms, Standards task group, Dr. Minkoff		3. Recommendations for standards formalized. 4. Recommendations are approved by providers and all DMH planning bodies.	
	4.4.3 The task group's recommendation is submitted to community providers and collaborating agencies for review, comment, and modifications made feedback received.	Molly Brooms	Molly Brooms, Kathy Seifried, CODC, Standards task group			
	4.4.4 Recommendations are channeled through DMH's planning process and incorporated into standards, as appropriate.	Molly Brooms	Kent Hunt, Kim Ingram, CODC, Dr. Minkoff			
4.5 Certification Standards include guidelines for cultural competency.	**4.5.1** The standards workgroup will research and identify appropriate guidelines that can be incorporated in the standards.	Molly Brooms	Molly Brooms,Standards task group			
4.6 Complimentary practice guidelines for DMH's substance abuse and mental illness divisions are created and implemented.	**4.6.1** The treatment improvement committee task groups establishes an array of best practice guides and other resources to assist providers in establishing Dual Diagnosis Capable and Enhanced programming that is consistent with the principles of the CCISC.					
	4.6.2 Recommendations are channeled through DMH's planning process and incorporated into standards and practice guidelines, as appropriate.					
	4.6.3 The committee monitors and solicits regional activities, reports, program outcome data, and consumer satisfaction surveys to identify best practices in Alabama.					

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	4.6.4 Practice guidelines are published online to allow for easy updating.					

Progress to Date	**Barriers and/or Situational Changes**	**Immediate Next Steps (including potential technical assistance needs)**

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PRIORITY 5: ***Train providers to screen, assess, and develop preventive interventions and treatment plans for people who have co-occurring disorders.***						
Strategy(-ies)	**Action(s)**	**Manager[1]**	**Implementer[2]**	**Expected Outcomes**	**Benchmarks**	**Completion Date (Estimated)**
5.1 DMH's provider workforce is assessed for co-occurring competency.	**5.1.1** Using the CODECAT™ fidelity tool, clinicians in each provider agency will be assessed to determine training needs.	Co-occurring Program Director	Kathy Seifried, Molly Broom, Dr. Minkoff, Provider organizations	1. Training needs relative to implementation of the CCISC are identified. 2. A baseline for measuring systems' change is established.	1. Licensure obtained for use of CODECAT™. 2. Process for implementation of CODECAT™ developed. 3. CODECAT™ assessment complete.	1. December 30, 2004
5.2 The provider workforce is trained to competently serve individuals with co-occurring disorders,	**5.2.1** Training objectives established for each region based upon the CODECAT™ results, provider requests, and provider certification and contract monitoring reports.	Co-occurring Program Director	Kathy Seifried, Molly Broom, CODC, Dr. Minkoff	1. All providers receive training needed to competently serve individuals with co-occurring disorders. 2. All providers receive training in cultural competency.	1. A training plan is developed for each region based upon assessed needs. 2. Each plan includes training for cultural competency. 3. Resources are identified to implement each plan.	1. September 30, 2005

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	5.2.2 DMH leverages all available resources to address current training needs, including: a. DMH's system change consultant, Dr. Kenneth Minkoff b. DMH's implementation team c. TA available through the Substance Abuse Prevention and Treatment Block Grant d. TA available through the Community Mental Health Block Grant e. TA available through the Co-occurring Academy f. TA available through the Robert Wood Johnson Foundation g. TA available through the Southern Coast Addiction Technology Transfer Center h. DMH's current train-the trainer initiative i. Other state and local agencies	Co-occurring Program Director	Kent Hunt, Kim Ingram, CODC		4. Training schedules are developed and training is provided. 5. Post training evaluation is conducted.	

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5.3 DMH engages in collaborative training and workforce development activities.	**5.3.1** DMH pursues partnerships with colleges and universities to address ongoing workforce needs.	Co-occurring Program Director	CODC, Outreach Specialist	1. Formal collaborative training and workforce development projects are established between DMH and Alabama colleges and universities.	1. Technical assistance obtained to identify ideas and resources for collaborative projects. 2. Workforce survey data and other reports are disseminated to colleges and universities to support DMH need for development of co-occurring clinical competencies in behavioral and physical health training programs. 3. Meetings at held with at least 10 colleges and/or universities to discuss DMH needs, and present recommendations for collaboration. 4. A positive response is received from 50% of the contacts made and projects are developed.	December 31, 2005

Progress to Date	**Barriers and/or Situational Changes**	**Immediate Next Steps (including potential technical assistance needs)**

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PRIORITY 6: ***Evaluate the impact of prevention and treatment services on individuals who have co-occurring disorders and their families.***						
Strategy(-ies)	**Action(s)**	**Manager[1]**	**Implementer[2]**	**Expected Outcomes**	**Benchmarks**	**Completion Date (Estimated)**
6.1 DMH's SA and MI providers utilize common performance indicators.	**6.1.1** A program evaluation committee is established that includes appropriate representation of all stakeholders.	Kathy Seifried	CODC	1. Program Evaluation Committee exists.	1. Potential task group members identified and contacted. 2. Task group reflects cultural diversity and includes consumer and family participation. 3. Meetings held as scheduled.	September 30, 2004

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	6.1.2 The committee identifies various sources of performance indicators for study, including, a. Those currently utilized by the SA and MI divisions and provider organizations b. The CCISC fidelity instruments. c. Federal, state and other regulatory agencies. d. Other state agencies.	Kathy Seifried	Program Evaluation Committee, CODC, Dr. Minkoff	1. Performance indicators exist for every level of the COD system.	1. A list of performance indicators currently used by SA and MI is established, and compared for duplication and relevance to co-occurring initiative. 2. Performance indicators are gathered form other states and resources. 3. Indicators are selected to meet essential regulatory requirements, as well as, provide DMH with what it needs to know to effectively serve individual with co-occurring disorders. 4. Committee recommendations are submitted to relevant stakeholders for review and comment. 5. Indicators incorporated into practice guidelines for COD.	1. December 30, 2004

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6.2 Performance benchmarks are established for each priority population.	**6.2.1** Data sources for performance benchmarks are identified.	Kathy Seifried (until co-occurring program director is hired)	Program Evaluation Committee, CODC, Dr. Minkoff	1. Relevant performance benchmarks exist for the treatment of COD in Alabama.	1. Literature search conducted to identify appropriate provider performance and clinical outcome benchmarks. 2. Desired benchmarks and data sources are identified. 3. Technical and other obstacles to data collection to measure benchmarks identified. 4. Benchmarks are selected that represent best practice guidelines. 5. Committee recommendations are submitted to relevant stakeholders for review and comment. 6. Benchmarks are incorporated into practice guidelines for COD.	September 30, 2005

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6.3 A reliable system of data collection and reporting exists.	**6.3.1** Policies and procedures governing data collection and reporting are developed.	Co-occurring Program Director	CODC, SA and MI Personnel, DMH Data Management Personnel, Program Evaluation Committee.	1. A clearly defined process of data collection and reporting to support program evaluation is utilized.	1. All current data reporting requirements and data sources for SA and MI are identified. 2. Duplicative processes are identified. 3. Technical assistance obtained to assist in developing procedures to meet data needs. 4. The feasibility of third party data collection (possibly a university) is explored and the cost-benefits examined. 5. Written plan developed for data collection. 6. Resources identified to support plan. 7. All key stakeholders informed of plan. Plan implemented.	September 30, 2005
6.4 A state-of-the art management information system supports program evaluation activities, and other business practices.	**6.4.1** MI and SA share information relative to current initiatives to implement state-of-the art management information systems. **6.4.2** MI and SA identify functional requirements of a management information system to meet the needs of both agencies. **6.4.3** The current readiness of providers to submit data electronically is assessed	Co-occurring Program Director	CODC, SA and MI Personnel, DMH Data Management Personnel, Program Evaluation Committee.	1. A management information system, providing reliable support for DMH business practices is operational.	1. Committee minutes reflect MI and SA collaboration . 2. Functional requirements for a unified MIS are established. 3. Provider infrastructure needs are identified.	September, 2006.

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	6.4.4 Other states' systems are studied				4. Technical assistance is obtained to assist in identifying needs. 5. Written plan developed for MIS. 6. Resources identified to support plan. 7. All key stakeholders informed of plan. 8. Plan implemented	
6.5 Program evaluation findings are used to drive systems change, identify best practices, and support social marketing efforts	**6.5.1** A procedure to evaluate service delivery processes, outcome, utilization data, and fidelity to the CCISC is established.	Co-occurring Program Director	Program Evaluation Committee, Dr. Minkoff	A COD systems evaluation plan is developed and utilized to support the COD initiative	Evaluation questions are developed. Data sources for answering evaluation questions are identified. Timetables for program evaluation are established. Resources to assist in program evaluation activities are identified. Plan is constructed and implemented.	October 1, 2006
	6.5.2 Policies and procedures are developed to assure the provision of feedback of evaluation findings to DMH, providers, collaborating partners, regulatory bodies, consumers/clients, and families.	Co-occurring Program Director	Program Evaluation Committee, Dr. Minkoff, CODC	Key stakeholders in Alabama have access to DMH's COD program evaluation findings. Feedback resulting from program evaluation findings are utilized to improve service access and delivery for individuals with co-occurring disorders.	Program evaluation findings are disseminated through various venues, including the Internet, direct mail-outs, provider meetings, etc. Written protocol exists for distribution of program evaluation findings.	October 1, 2006

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Progress to Date		**Barriers and/or Situational Changes**		**Immediate Next Steps (including potential technical assistance needs)**		

[1] The Manager is the individual responsible for coordinating each action.

[2] The Implementer is the individual (or entity) responsible for carrying-out each action.

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PRIORITY 7: ***Provide funding to support development and enhancement of services for individuals with co-occurring disorders***						
Strategy(-ies)	**Action(s)**	**Manager[1]**	**Implementer[2]**	**Expected Outcomes**	**Benchmarks**	**Completion Date (Estimated)**
7.1 Areas of funding need are identified.	**7.1.1** Service gaps, relative to location, modality, capacity, special population needs, etc. are identified.	Kent Hunt, Kim Ingram	CODC, SA and MI Personnel	Area's of funding need are identified.	Regional strategic plans and other available data are utilized to identify service gaps and make recommendations. A service reimbursement report, with recommendations based upon committee research is generated. A salary survey report, with recommendations based upon committee research is generated.	September 30, 2005
	7.1.2 Current DMH service reimbursement processes are examined for both SA and MI and compared to that of other state SA and MI agencies.					
	7.1.3 DMH provider salary survey findings are compared to those of other state behavioral health agencies.					
7.2 Existing funding resources are maximized.	**7.2.1** Technical assistance is obtained to modify service descriptions and set appropriate reimbursement rates for Dual Diagnosis Capable and Enhanced Services.	Co-occurring Disorders Program Director	Kent Hunt, Kim Ingram	Access to care is improved through more efficient use of existing resources.	Service descriptions and reimbursement rates reflect best practices. SA and MI have a common Medicaid benefit. SA and MI participate in cost saving purchasing arrangements. SA and MI policies and procedures are consistently monitored for duplication through quality assurance processes.	
	7.2.1 A common benefits package is established for Medicaid eligible consumers who have co-occurring disorders.					
	7.2.2 MI and SA identify and participate in shared purchasing arrangements.					
	7.2.3 MI and SA identify opportunities to participate in shared purchasing arrangements with other state agencies.					
	7.2.4 MI and SA policies and procedures are examined for duplication of effort.					

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7.3 New funding resources are identified.	**7.3.1** MI and SA establishes a grant notice clearinghouse and assigns responsibility for seeking new funding opportunities to a departmental employee.	Kent Hunt, Kim Ingram	Kent Hunt, Kim Ingram	Funding to support co-occurring disorders treatment in Alabama increases by 50%.	MI and SA receive timely notification of funding opportunities. Applications for new funding are generated, at a minimal, bi-monthly. SA and MI identify at least three joint funding opportunities annually.	September 30, 2005
	7.3.2 SA and MI submit joint applications for funding to support co-occurring disorders treatment.					

Progress to Date	**Barriers and/or Situational Changes**	**Immediate Next Steps (including potential technical assistance needs)**

[1] The Manager is the individual responsible for coordinating each action.

[2] The Implementer is the individual (or entity) responsible for carrying-out each action.